Athletic Physical Form

Name: _____ Age: _____ D.O.B: _____ Grade: _____

Date Of Exam: _____ Sport(s): _____

Address: _____ Home Phone: _____

Guardian 1: _____ Work Phone: _____

Guardian 2: _____ Work Phone: _____

Emergency Contact: _____ Phone No.: _____

Medical History

Significant Previous Injuries:		No		Yes:						
Hospitalizations or Surgeries:		No		Yes:						
Bone or Joint Injuries:		No		Yes						
Current Medications:		No		Yes:						
Past Medications:		No		Yes:						
Chronic Illness:		No		Yes:						
Allergies:		No		Yes:						
Vaccinations are Current:		Yes		No:						
Seizures:		No		Yes	Glasses or Contact Lenses:		No		Yes	
Asthma:		No		Yes	Fainting/Dizzy Spells:		No		Yes	

Physical Exam

Height: _____ Weight: _____ Blood Pressure: _____

Feature	Result	Comments
General		
Eyes		
Nose		
Dental/Mouth		
Throat		
Ears		
Skin		
Cardiovascular		
Musculoskeletal		
Neurological		
Genitourinary		
Gastrointestinal		
Spinal		
Nutritional Status		
Mental Health		

Additional Comments: _____

I approve this student's participation in interscholastic sports for one (1) year. ☐ Yes ☐ No

Physician: _____ Signature: _____ Date: _____

PNP: _____ Signature: _____ Date _____